Special Assistance In-Home Program

Pursuant to S.L. 2005-276 (SB 622), Section 10.39(b) and (c)

Report
To
House of Representatives Appropriations Committee
and
House of Representatives Appropriations Subcommittee
On Health and Human Services
and
Senate Appropriations Committee
and
Senate Appropriations Committee
On Health and Human Services

January 2007

Prepared by
North Carolina Department of Health and Human Services
Division of Aging and Adult Services

Special Assistance In-Home Program

I. Background

The State/County Special Assistance (SA) for Adults Program provides a cash supplement to help pay for the care of eligible low-income adults residing in adult care homes. The SA Program originated as the State Boarding Home Fund in 1951. For SFY2007, $145,630,676 is budgeted. The state and counties share equally in the cost of the SA Program. The Special Assistance In-Home Program (Program), initiated as a demonstration program in 1999, provides an option for in-home care for older and disabled adults who are in need of placement in an adult care home, but who desire to live in a private living setting and can be maintained safely in that setting.

A. Legislation

The General Assembly approved a special provision in S.L. 1999-237, Section 11.21 authorizing the Department of Health and Human Services (Department) to carry out a demonstration project (the SA Demonstration Project) to provide Special Assistance for up to 400 eligible individuals living at home for a two-year period beginning July 1, 1999 and ending June 30, 2001. Interim reports were submitted to the General Assembly in August 2000, July 2001, and July 2002. The General Assembly amended the special provision in S.L. 2000-67, Section 11.13 to provide these Special Assistance payments through June 2002. The General Assembly subsequently amended the special provision in S.L. 2001-424 to increase the payment standard to 50% of the amount paid to adult care home recipients, to allow payments through June 30, 2003, and to require the Department to submit a final report by January 1, 2003. Prior to the amendment, the payment standard was the difference between the client's income and the federal poverty level, which proved to be an impediment to appropriately serving many impoverished clients due to the limitations created by the earlier payment standard.

In the 2003 session, the General Assembly approved a special provision in S.L. 2003-284, Section 10.51(a) authorizing the Department to expand the Special Assistance In-Home Program (formerly referred to as the SA Demonstration Project) to 800 slots statewide, with counties participating on a voluntary basis. The provision specified that no eligible individuals would receive a payment less than they would have received in SFY 2003 and continued the maximum payment at 50% of the amount the individuals would receive if living in an adult care home. The actual amount of the payment is based on a needs assessment conducted by a case manager in the county department of social services (DSS). The special provision also required the Department to submit a report to the General Assembly by January 1, 2004 and a final report by January 1, 2005.

The General Assembly approved a special provision in S.L. 2005-276 (SB 622), Section 10.39(a) during the 2005 session which authorized expansion of the SA/In-Home Program to 1,000 slots statewide, with voluntary county participation. The special provision also increased the maximum monthly payment to individuals enrolled in the Special Assistance In-Home Program. The maximum monthly payment increased from 50% to 75% of the monthly payment the individual would receive if the individual resided in an adult care home and qualified for Special Assistance. The actual amount of

the payment continues to be based on a needs assessment conducted by a case manager in the county DSS.

During the 2006 Short Session, the General Assembly approved S.L. 2006-156 (HB 2576) which increased the number of slots to 1,500 effective July 1, 2006.

This report, required by S.L. 2005-276, Section 10.39(b), contains a description of cost savings resulting from the SA/In-Home Program, including an analysis of federal, state and county funds expended; descriptive information about the Program, including case management provided and types of services provided to SA/In-Home recipients; and recommendations as to the continuation or expansion of the Program. This report also includes results of the quality of life comparison required by Section 10.39(c). Section 10.39(b) and (c) and S.L. 2006-156 are included in Appendix A.

Within the Department, responsibility for administration of the Special Assistance Program and the Special Assistance In-Home Program shifted from the Division of Social Services to the Division of Aging and Adult Services, effective September 1, 2003. This occurred with the merger of the Adult Services Section, formerly a part of the Division of Social Services, into the renamed Division of Aging and Adult Services.

B. Participating Counties

The original special provision authorizing the SA/In-Home Program limited the number of SA/In-Home recipients to 400 people. Since it was not feasible for all 100 county DSSs to participate in a project with such a small number of people, a Request for Proposals was sent to all county DSS agencies in April 2000 notifying them about the project, the conditions of participation, and requesting that all interested agencies submit their proposals. Twenty-two (22) county DSSs responded with proposals, and all were approved to participate.

When the 2003 General Assembly authorized expansion of the Program, Requests for Proposals were sent to all county DSSs in July 2003. County DSSs that had not previously participated were invited to submit proposals, and county DSSs already participating were invited to request additional slots if appropriate to their local needs.

The response from the county DSS agencies was very positive. It should be noted that the counties assume the entire matching requirement for the Medicaid-funded case management required for the service; the state does not participate. Thirty-six (36) county DSSs submitted proposals indicating a desire to provide this Program and the commitment of local resources to participate. After taking into account the need for statewide geographical distribution; the need for participation by small, medium, and large county DSS agencies; and the ability of the county DSS agencies to provide case management to these adults with existing funding sources, the decision was made to approve all requests to participate. The newly participating county DSSs were notified of their approval, with an effective date of October 1, 2003, and arrangements were made to train their staff.

During the Fall of 2004, additional requests for county participation were solicited in order to maximize usage of available slots. Two additional counties (Beaufort and Stokes) were added to the Program in December 2004, increasing the total number of participating counties to 60.

The 2005 session of the General Assembly authorized further expansion of the Program and Requests for Proposals were issued to all 100 county DSSs in September 2005. County DSSs that had not previously participated were invited to submit proposals, and county DSSs already participating were invited to request additional slots if appropriate to their local needs. Twelve additional county DSSs began providing this service and 34 currently participating county DSSs requested additional slots so that they could serve more adults.

During the 2006 Short Session, an additional 500 slots were authorized by the General Assembly, bringing the total number of slots to 1,500. The county DSSs' response was, as in the prior expansion opportunity, very positive. Fifteen new county DSSs requested participation in the Program and 54 currently participating county DSSs requested additional slots. After taking into account the need for statewide geographical distribution; the need for participation by small, medium, and large county DSS agencies; and the ability of the county DSS agencies to provide case management (a required component of the Program) to these adults with existing funding sources, the decision was made to approve all requests to participate. One-hundred five (105) slots were awarded to the fifteen new counties and the remaining 395 slots were distributed to the 54 currently participating county DSSs that requested additional slots. The county DSSs were notified of their approval with an effective date of September 2006.

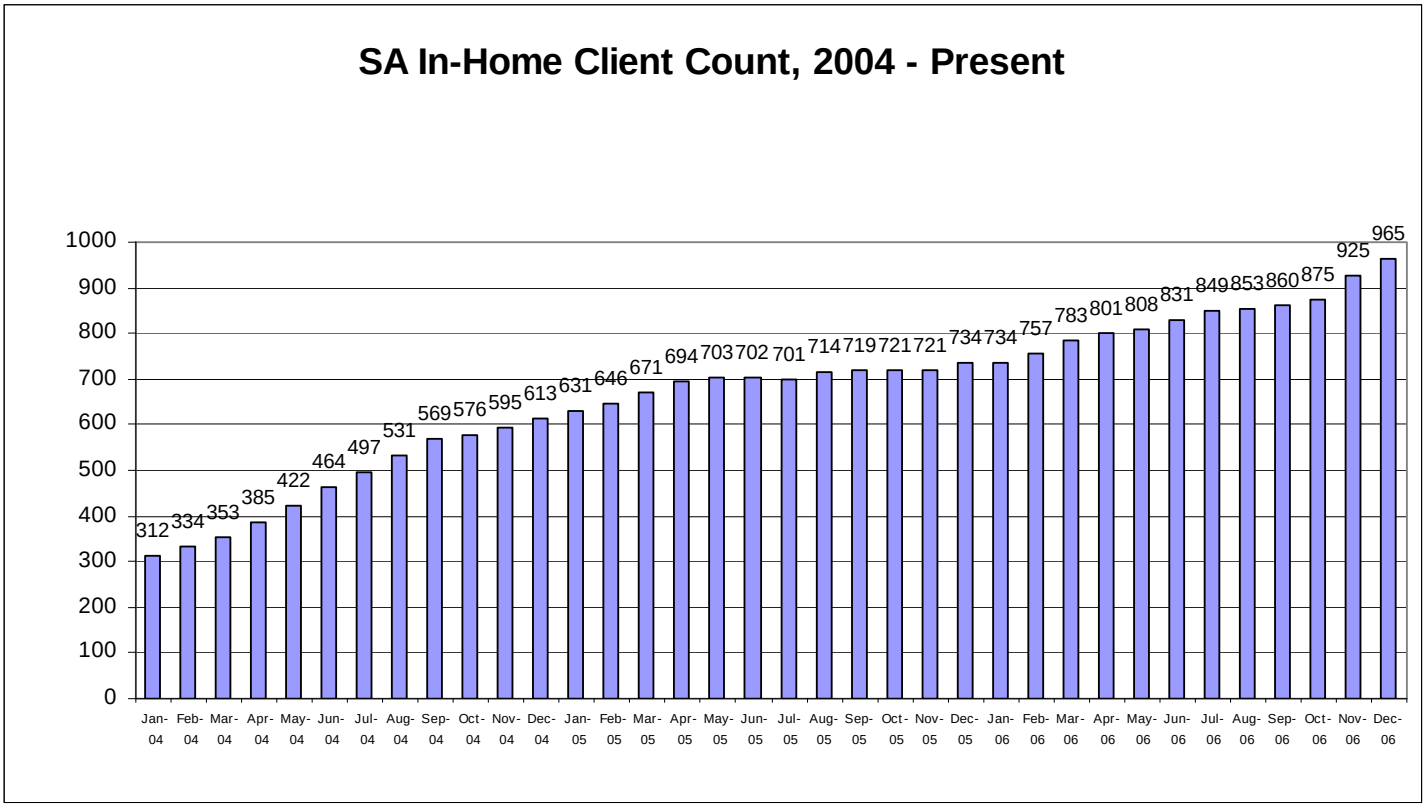
A list of the 87 county DSS agencies participating in the program is shown below.

SA/In-Home Program Counties			
Alamance [2]	Dare [1]	Lee [2]	Randolph [2]
Alexander [5]	Davidson [2]	Lenoir [2]	Robeson [1]
Ashe [2]	Davie [4]	Lincoln [1]	Rockingham [2]
Avery [5]	Duplin [5]	Macon [5]	Rowan [1]
Beaufort [3]	Durham [2]	Madison [5]	Rutherford [2]
Bertie [2]	Edgecombe [4]	Martin [2]	Sampson [2]
Bladen [2]	Forsyth [2]	McDowell [4]	Scotland [2]
Buncombe [2]	Franklin [2]	Mecklenburg [1]	Stanly [4]
Burke [4]	Gaston [2]	Mitchell [5]	Stokes [3]
Cabarrus [1]	Gates [5]	Montgomery [5]	Surry [2]
Caldwell [2]	Graham [1]	Moore [2]	Swain [2]
Carteret [5]	Guilford [1]	Nash [4]	Transylvania [2]
Caswell [2]	Halifax [4]	New Hanover [2]	Union [2]
Catawba [2]	Harnett [1]	Northampton [1]	Vance [4]
Chatham [1]	Haywood [2]	Onslow [1]	Wake [2]
Cherokee [4]	Henderson [2]	Orange [2]	Watauga [2]
Clay [4]	Hertford [2]	Pamlico [1]	Wayne [2]
Cleveland [1]	Hoke [4]	Pasquotank [1]	Wilkes [5]
Columbus [1]	Hyde [5]	Pender [2]	Wilson [2]
Craven [1]	Iredell [1]	Person [5]	Yadkin 4
Cumberland [1]	Jackson [5]	Pitt [1]	Yancey 5
Currituck [1]	Johnston [1]	Polk [5]	

[1] Original 22 participating counties (September 2000)
[2] Counties added October 2003
[3] Counties added December 2004
[4] Counties added November 2005
[5] Counties added September 2006

Appendix B includes a map of North Carolina that highlights the participating counties in the chart on the previous page and illustrates the widespread coverage of the Program throughout the state. A table displaying the geographic location of the 965 SA In-Home clients as of December 1, 2006 is also included in Appendix B.

The following graph and table display the growth in participation that has occurred over the period of January 2004 to December 2006. Slot utilization more than tripled, increasing by over 209% during this three-year time frame.



2004	Client Count	Percentage increase from prior month	2005	Client Count	Percentage increase from prior month	2006	Client Count	Percentage increase from prior month
January	312		January	631	3%	January	734	0%
February	334	7%	February	646	2%	February	757	3%
March	353	6%	March	671	4%	March	783	3%
April	385	9%	April	694	3%	April	801	2%
May	422	10%	May	703	1%	May	808	1%
June	464	10%	June	702	0%	June	831	3%
July	497	7%	July	701	0%	July	849	2%
August	531	7%	August	714	2%	August	853	0%
September	569	7%	September	719	1%	September	860	1%
October	576	1%	October	721	0%	October	875	2%
November	595	3%	November	721	0%	November	925	6%
December	613	3%	December	734	2%	December	965	4%

II. SA/In-Home Clients

A total of 1,039 individuals received SA/In-Home payments during SFY2005-06. The data shown in the charts and graphs that follow is for the individuals who were active SA/In-Home recipients during this twelve month period. The data was collected by the case managers using the Resident Assessment Instrument (RAI) © - Home Care, which is the assessment instrument for the SA/In-Home Program.

As assessments are completed by the case managers, the data is stored in a database in the case managers' laptop computers. The data for recipients in each county is then saved to a computer disk and mailed to the Division of Aging and Adult Services biweekly where it is merged with data from all participating counties.

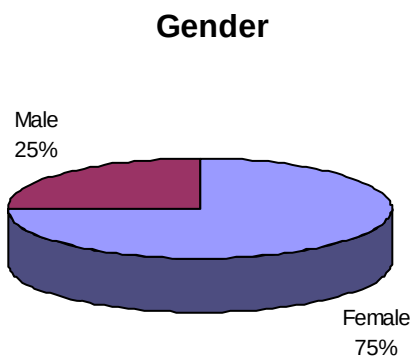
The overall assessment data for the Program shows the characteristics and functioning levels of the SA/In-Home recipients. The SA/In-Home recipient data provides a description of the types of individuals receiving these funds and using them to live at home rather than entering an adult care home. Data of this type is not collected for SA recipients in adult care homes. Thus, comparison of the two groups of SA recipients is not possible.

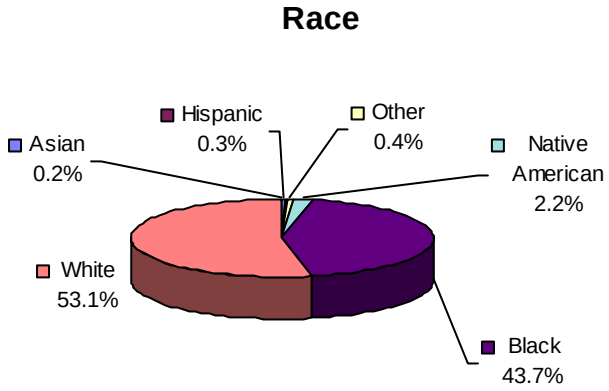
The charts and graphs show information about the demographics, living arrangements, and other characteristics of these individuals. The typical SA/In-Home recipient is female and lives alone. More than two-thirds of the recipients are age 60 or older. The average monthly income is $570.69. The primary caregiver is an adult child.

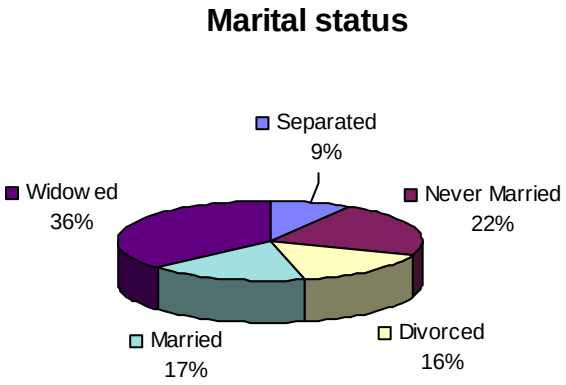
The most elderly client currently in the Program celebrated her 106th birthday on November 28, 2006. She and a 95 year old relative share a home.

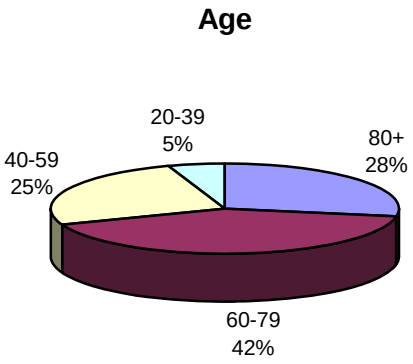
A. Basic Demographics

The pie charts below reflect basic demographic data about the gender, race, marital status, and age of the 1,039 individuals who have received SA/In-Home payments during the period of July 2005 through June 2006.



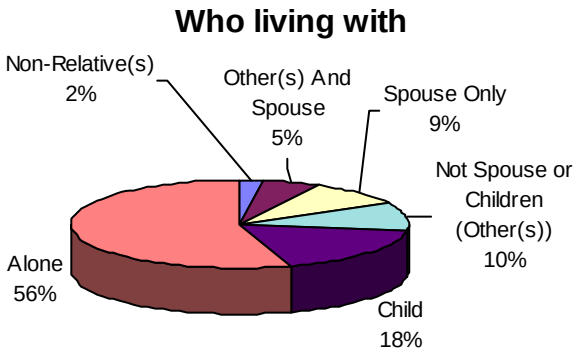






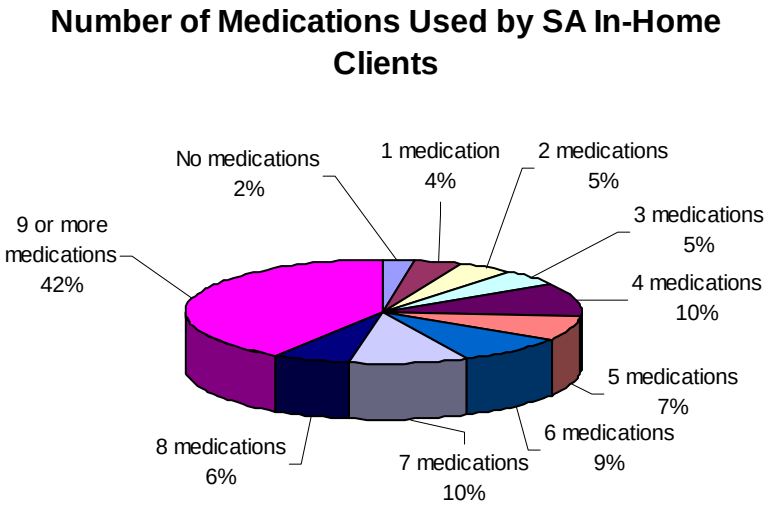
B. Living Arrangements

This chart shows with whom the SA/In-Home clients live. All participants live in a private living arrangement and more than half live alone.



C. Medications

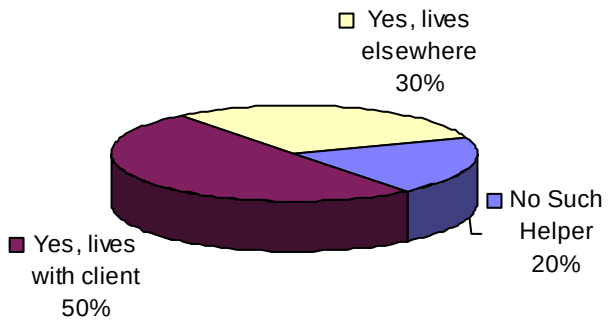
The SA/In-Home recipients have a wide variety and range of health conditions. They take a variety of prescription and over-the-counter medications. The number of medications taken is shown to the right. 58% of the recipients take 7 or more medications; 42% of the recipients take 9 or more medications. Approximately 4% of the SA/In-Home payments were used to assist with medication expenses.



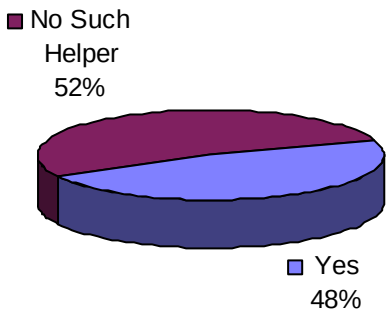
III. Caregivers

The role of caregivers is very important in determining whether an older or disabled adult is able to live at home instead of going to an adult care home. The following pie charts reflect that 80% of the recipients have a primary caregiver and 48% have a secondary caregiver. Fifty percent of the primary caregivers live with the client which is consistent with the finding that 56% of the SA/In-Home clients live alone. Twenty percent of the clients were found to have no primary informal caregiver.

Presence of a Primary Caregiver

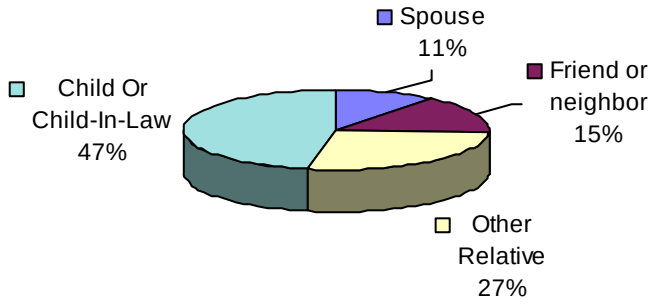


Presence of a Secondary Caregiver



Caregivers include relatives, friends, and neighbors. These caregivers provide a range of help to these individuals – including assisting with activities of daily living, instrumental activities of daily living, advice, and emotional support. Forty-seven percent of the primary caregivers are either a child or child-in-law of the SA/In-Home recipient.

Relationship of Primary Caregiver to Client



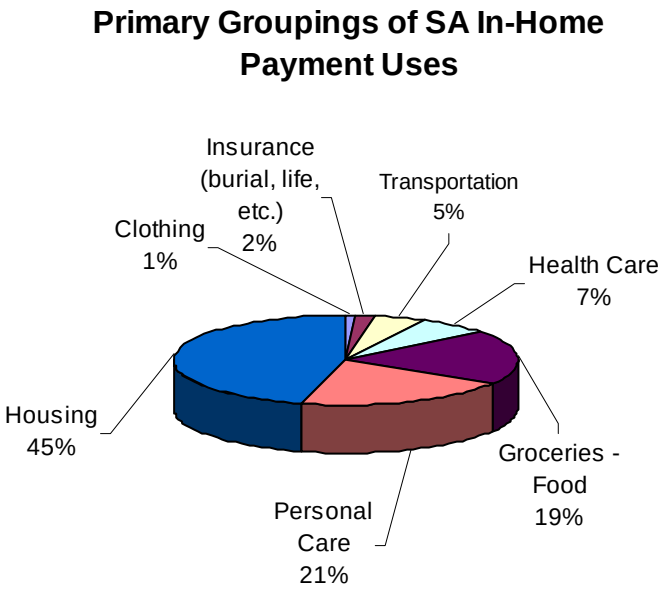
IV. Use of SA/In-Home Payments

Case managers develop care plans based on findings from the client assessments and planning with the clients, their family members, friends or other members of their informal support network, physicians and local service providers. The care plans are designed to meet the needs of the clients and enable them to live at home rather than move to an adult care home. Part of the care plan addresses how the SA/In-Home payments are to be used to enable the client to live at home safely. The SA payments have been used for a variety of supports – all of which are basic needs for people living at home. A primary issue for many of these individuals is that they do not have sufficient income to meet their needs – and that, along with other factors, has put them at risk of leaving home and moving into an adult care home. The average monthly income for these individuals during the July 2005 - June 2006 period was $570.69.

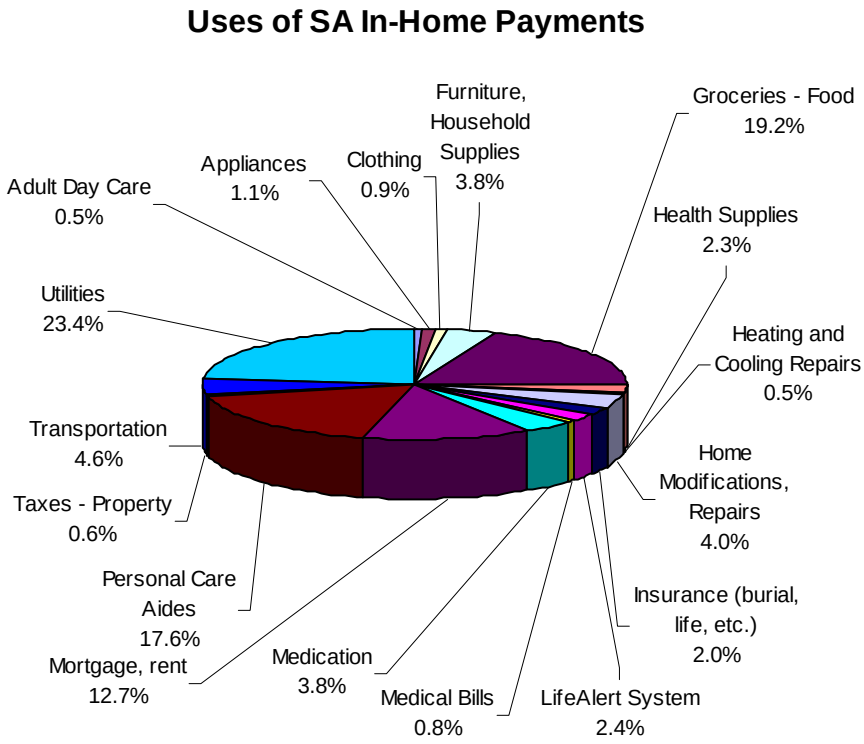
The case managers work with the clients in the following ways to determine the need for Special Assistance payments at home:

- conduct a face-to-face assessment with the client and the family or other members of the client's support network to determine the needs and resources available to meet the needs;
- make a visit to the place where the client is living (or was going to live in situations where he needed to move to other housing in order to live in the community safely);
- work with the client and family on what items the SA payment is needed for;
- determine the amount of SA payment needed for these items, up to the maximum payment allowed;
- authorize the monthly SA payment amount; and
- monitor to assure that the SA payments are used for the approved purposes.

The pie chart to the right shows the broad categories of items the SA/In-Home payments are used for and the percent of approved SA payments for these items. This data is for the 1,039 clients who received SA/In-Home payments during July 2005 - June 2006. The average monthly payment was $276.91 per client. The SA/In-Home payments are used for a variety of basic needs: housing, health care, food, personal care, clothing, and transportation. The most prevalent use is for housing: 45% of the payments are used for housing. The housing category includes utilities, home modifications, furniture, rent, appliances, heating and cooling repairs, and property taxes.



An examination of the more detailed uses of the SA/In-Home payments shows that utility bills (23.4%) make up the largest single category of the payments when the housing category is broken into subparts. Groceries follow as the next largest single category (19.2%). This is consistent with assessment data that shows 37% of the SA/In-Home clients report having to make "trade off" decisions, such as purchase of food or heat versus required medications. Purchase of personal care assistance is the third largest single category (17.6%).



V. Medicaid Services

A. Coordination with Medicaid Eligibility Policies and Procedures

The Division of Aging and Adult Services continues to work cooperatively with the Division of Medical Assistance (DMA) to coordinate the SA/In-Home eligibility policies and procedures with Medicaid eligibility policies and procedures.

A condition for participation in the SA/In-Home Program is that individuals be eligible for Medicaid. Eligibility for Medicaid is established separately from eligibility for SA/In-Home payments. The income level for Medicaid for Aged, Blind, and Disabled Adults in private living arrangements is 100% of the federal poverty level (currently $817 per month for an individual). Anyone with income above 100% of the federal poverty level is not eligible to receive SA/In-Home payments. The average monthly income for the SA/In-Home recipient is $570.69 which contrasts with the $691.90 average monthly income of SA/Adult Care Home recipients.

Special Assistance recipients who live in adult care homes are automatically eligible for Medicaid**.** This provision is included in the Medicaid State Plan for North Carolina, since individuals covered by a state's Optional State Supplement Program are automatically eligible for Medicaid coverage. Special Assistance is an Optional State Supplement and is considered to be an income supplement to the Supplemental Security Income (SSI) Program. The Special Assistance Program is administered in accordance with federal SSI and Medicaid regulations in addition to state laws and rules that govern this Program.

While SA/In-Home recipients must be eligible for Medicaid, they are not automatically eligible for Medicaid, unless they are SSI recipients. SA/In-Home recipients with incomes between the SSI income limit ($623 per month beginning January 2007) and the federal poverty level ($817 per month) are not automatically eligible for Medicaid, even if they qualify for an SA/In-Home payment. SA/In-Home recipients not already receiving Medicaid have to complete a separate Medicaid application to determine whether they are eligible for Medicaid.

The federal poverty level was established as the need standard (eligible income level) for the SA/In-Home payments to be consistent with the eligibility income level for Medicaid for older and disabled adults. This ensures that all SA/In-Home recipients are Medicaid eligible based on income so they may utilize Medicaid covered services to help them live at home. Medicaid covers the cost of health care such as physician services, hospital care, prescription drugs, dental care, durable medical equipment, home health services, home infusion therapy, hospice, personal care services, private duty nursing and other services provided to older and disabled adults residing in private living arrangements. Medicaid coverage, along with the SA/In-Home payment, is an essential element for giving individuals a choice of living at home rather than moving to an adult care home.

Attempts to make all SA/In-Home Program recipients automatically eligible for Medicaid have been made. The Division of Medical Assistance received an interpretation from the

Health Care Financing Administration (now the Centers for Medicare and Medicaid Services, or CMS) in June 2000 indicating the SA/In-Home Program was considered a "demonstration project" that was time limited, available to a limited number of individuals in specific counties, and not included in the Medicaid State Plan as part of the statewide Optional State Supplement Program. Thus, SA/In-Home recipients cannot receive Medicaid coverage automatically. CMS was again asked in December 2005 to consider automatic Medicaid eligibility for SA/In-Home recipients since the Program had expanded to 72 counties and has been made available to all 100 counties, and is no longer classified as a demonstration project. CMS was recently advised of the expansion to 87 counties and 1,500 slots. A response from CMS is pending at this time.

B. Medicaid Service Cost Comparison

The Division of Medical Assistance provided data about the types and costs of Medicaid services provided to SA/In-Home recipients as well as to SA/Adult Care Home recipients for SFY2005-06 (July 1, 2005 through June 30, 2006). The data is shown in the table on the next page. This data provides a comparison of the Medicaid services and costs for the two groups of recipients.

The data reflects claims paid by Medicaid for services provided to both groups of SA recipients. 659 SA/Adult Care Home recipients who lived in adult care home settings throughout SFY2005-2006 were randomly selected for comparison to the 659 people who participated in the SA/In-Home Program during the entire SFY2005-06. The total sample used to determine the cost of Medicaid covered services during this time period was therefore 1,318 individuals: 659 In-Home recipients and 659 Adult Care Home recipients. All 1,318 of these individuals were SA recipients in their respective settings (In-Home and Adult Care Home) for all twelve months in SFY05-06. Medicaid service providers have one year from date of service to submit claims for payment. Since there can be a lag time of up to one year from date of service to date of billing, a small amount of Medicaid costs may not be reflected in the table on the next page.

The top three Medicaid services with the highest level of expenditures for both groups were Personal Care Services ($7.1 million), Prescription Drugs ($5.3 million), and Physician Services & Hospitalization ($2.1 million).

The table gives a breakout of each Medicaid service, the number of recipients receiving the services in each setting of care, the total cost and average cost per recipient for each setting of care, and the total cost and average cost per claim for each setting of care. As shown in the table, the average total cost per recipient for all Medicaid services used by the 659 SA/In-Home recipients during this 12-month period was $13,984. The average total cost per recipient for all Medicaid services used by the 659 SA/Adult Care Home recipients during this 12-month period was $17,988. An average savings of $4,004 for SA/In-Home recipients was realized during the period.

Medicaid Services Provided to SA/In-Home and SA/Adult Care Home Recipients During Period of July 2005 – June 2006 [1]

	SA/In-Home clients (N = 659)					SA/Adult Care Home clients (N = 659)				
Medicaid Service	**Number of SA/IH Clients Using the Medicaid Service**	**Total Medicaid Costs for SA/IH clients**	**Average Cost Per Client**	**Number of Medicaid Claims for the Service**	**Average Cost per Claim for the Service**	**Number of SA/ACH Clients Using the Medicaid Service**	**Total Medicaid Cost for SA/ACH Clients**	**Average Cost Per Client**	**Number of Medicaid Claims for the Service**	**Average Cost per Claim for the Service**
Personal Care Services	422	$2,945,319	$6,979	13,398	$220	637	$4,246,622	$6,667	11,806	$360
Prescription Drugs	649	$2,311,325	$3,561	31,268	$74	653	$3,044,220	$4,662	36,628	$83
Physician Services & Hospitalization	643	$1,484,854	$2,309	20,424	$73	635	$688,704	$1,085	13,166	$52
Mental Health Clinics	23	$440,485	$19,152	3,189	$138	54	$1,425,094	$26,391	11,417	$125
Case Management - DSS	659	$563,675	$855	8,308	$68	260	$398,839	$1,534	6,666	$60
Home Health Services-Visits	263	$331,434	$1,260	1,804	$184	448	$402,233	$897	2,855	$141
CAP/MR	0	0	0	0	0	21	$623,327	$29,682	580	$1,075
Practitioners, non-Physician	61	$131,471	$2,155	331	$397	193	$365,431	$1,893	2,147	$170
Durable Medical Equipment	390	$202,326	$519	3,369	$60	298	$99,428	$334	2,329	$43
Medical Transportation	213	$60,080	$282	983	$61	632	$179,052	$283	12,458	$14
Emergency Room	244	$110,328	$452	680	$162	233	$58,070	$249	529	$110
Home Health Services-Supplies	81	$30,469	$376	401	$76	94	$21,559	$229	381	$56
Hospice Services	4	$23,141	$5,785	18	$1,286	1	$3,074	$3,074	3	$1,025
All Other Services [2]	651	$580,652	$892	4,509	$34	599	$298,303	$498	3,451	$13
SFY 2006 Totals	659	$9,215,559	$13,984	88,682	$129	659	$11,853,956	$17,988	104,416	$87
Average per month		$767,963	$1,165				$987,830	$1,499		

Notes:
[1] All dollar amounts in the table are rounded to the nearest whole dollar
[2] "All Other Services" includes Medicaid reimbursement for services such as dental, optical, etc.

VI. Cost Analysis

A. Special Assistance for SA/Adult Care Home and SA/In-Home Recipients

Special Assistance payments supplement an individual's income so that he/she will have sufficient resources to pay for care in an adult care home or, as a participant in the SA/In-Home Program to live safely at home. The individual must need adult care home level of care, as verified by a physician and documented on the FL-2, in order to qualify for an SA payment for an adult care home or to participate in the SA/In-Home Program.

The need standard (eligible income level) for the SA/In-Home Program is 100% of the federal poverty level. Currently, the federal poverty level is $817 per month for a family of one. If an individual's income is below this level, he/she may be eligible for an SA/In-Home payment. The federal poverty level was established as the need standard for the SA/In-Home payments to be consistent with the eligibility income level for Medicaid for older and disabled adults.

The payment standard for the SA/In-Home payment during SFY05 was up to, but no more than, 50% of the amount that the same individual would receive to pay for care in an adult care home. The payment may actually be less, depending on the comprehensive needs assessment and the service plan developed by the case manager in conjunction with the client, his/her family, and other significant parties. Eligible individuals receive a monthly cash payment for an amount up to the payment standard, depending upon their specific needs that are identified through assessment and development of a care plan.

During the July 2005 – June 2006 period, 1,039 individuals received SA/In-Home payments. 659 individuals participated in the Program for the entire fiscal year. The average monthly payment was $276.91 per month.

Effective October 1, 2005, the payment standard for the SA/In-Home monthly payment was increased by the General Assembly to be up to, but no more than, 75% of the amount that the same individual would receive to pay for care in an adult care home. The adult care home payment rate was also increased by the General Assembly from $1,084 to $1,118 per month, effective October 1, 2005. In addition, the adult care home payment rate was increased by the General Assembly from $1,118 to $1,148 per month effective January 1, 2007.

The need standard and payment standard for the SA/Adult Care Home payment, which pays for care in adult care homes, are one-and-the-same. The current standard is $1,184 per month ($1,118 for room and board + $46 for personal needs allowance+ $20 income disregard). This is 145% of the federal poverty level, which is considerably higher than the need standard for the SA/In-Home Program. If an individual's income is below this level, he/she may be eligible for an SA payment for care in an adult care home. Eligible individuals receive a monthly cash payment for an amount that is the difference between the need/payment standard and their personal countable income.

The average Special Assistance payment made to individuals in adult care homes during SFY2005-06 was $426.18 per month. The average monthly payment of $426.18 to adult care home recipients is $149.27 higher than the $276.91 monthly payment to individuals in their own homes. The average annual payment of $5,114 to adult care home recipients is $1,791 higher than the average annual payment of $3,323 to the in-home recipients.

B. Medicaid for SA/Adult Care Home and SA/In-Home Recipients

As stated in the previous section, the average cost per recipient for all Medicaid services used by the 659 SA/In-Home recipients (participating for the entire year) was $13,984 for SFY2005-06. The average cost per recipient for all Medicaid services used by the 659 randomly sampled SA/Adult Care Home recipients during this same time period was $17,988. This means that the total Medicaid cost to support the SA/Adult Care Home recipient was 28.6% higher than the cost of supporting the SA/In-Home recipient.

Proper comparisons of cost of care between SA/Adult Care Home recipients and SA/In-Home recipients are not easily achieved because client acuity cannot be accurately compared across these populations. Obviously, cost comparisons are most accurate when comparing care for individuals with the same medical acuity level. At present, medical need and acuity information is not readily available for SA/Adult Care Home recipients. The adult care home assessment tool is not collecting the same comprehensive data that is gathered on SA/In-Home recipients using the RAI©-HC. Therefore, care must be taken when drawing conclusions from the data because one cannot compare level of care indicators. However, it should be noted that the data used for this report was thoroughly reviewed to ensure accuracy and to verify that no costs were duplicated or inadvertently excluded.

Substantial differences between the two groups can be seen in the utilization of Prescription Drugs, Physician Services/Hospitalization, and Personal Care Services. Nearly equal numbers of SA/In-Home and SA/Adult Care Home recipients received Prescription Drugs, 649 and 653, respectively, however the costs were significantly different between the two groups. SA/Adult Care Home recipient Prescription Drugs costs were 31.7% higher. 422 SA/In-Home recipients received Personal Care Services at a total cost of $2,945,319 versus 637 SA/Adult Care Home recipients at a total cost of $4,246,622. Conversely, 643 SA/In-Home recipients incurred substantially more cost for Physician Services/Hospitalization ($1,484,854) than the 635 SA/Adult Care Home recipients ($688,704).

Medicaid case management programs provided by county DSS staff support the SA/Adult Care Home recipients (Adult Care Home Case Management Services) and the SA/In-Home recipients (At-Risk Case Management Services). The state share of the cost for Adult Care Home Case Management is 25%; there is no state participation in the At-Risk Case Management Services Program and counties are required to provide the entire non-federal share of this service (36.51% during SFY2005-2006).

C. Food Stamps for SA/In-Home Recipients

Food Stamps were received by 382 or 57.9% of the 659 SA/In-Home recipients who participated in the Program throughout the period of July 2005 – June 2006. The average food stamp allotment for these 382 individuals during this time period was $45 per month. Food stamps are a 100% federal benefit. No state funds are included in the food stamp benefits. SA/Adult Care Home recipients are not eligible for food stamps.

D. Home and Community Care Block Grant for SA/In-Home Recipients

Services funded by the Home and Community Care Block Grant (HCCBG) administered by the Division of Aging and Adult Services were used by 111 or 16.8% of the SA/In-Home recipients during the period of July 2005 – June 2006. The services provided include in-home aide services, adult day care/day health, home delivered meals, congregate nutrition, and transportation. Expenditures of $146,728 were made for these recipients during this time period. The average annual cost was $1,322 per recipient; the average monthly cost was $110. Approximately 53% of these amounts are state funds (based on federal, state and required local match). SA/Adult Care Home recipients did not receive HCCBG funded services during the period of July 2005 – June 2006.

E. Social Services Block Grant (SSBG) for SA/In-Home Recipients

The estimated amount of SSBG used to support 312 SA/In-Home recipients during the period of July 2005 – June 2006 was $954,061. During that same period, $429,594 in SSBG was used to support 56 SA/Adult Care Home recipients in the sample group. Forty-seven percent of the SA/In-Home recipients received SSBG services at an average monthly cost of $255. Eight percent (8%) of the SA/Adult Care Home recipients received SSBG services at an average monthly cost of $639. Only 8.22% in state funds are included in the SSBG amounts.

F. Combined Cost Comparison

The cost to serve a typical SA/In-Home recipient includes Medicaid, State-County Special Assistance, Food Stamps, HCCBG, and SSBG funds. The cost to serve a typical SA/Adult Care Home recipient includes Medicaid and State-County Special Assistance funds. The following tables aggregate the average monthly costs and savings to serve both populations.

	Comparison of Monthly Cost Per Recipient (rounded to nearest dollar)							
	SA/Adult Care Home Costs	**Federal share**	**State share**	**County share**	**SA/In-Home Costs**	**Federal share**	**State share**	**County share**
Medicaid	$1,499	$950	$453	$95	$1,165	$741	$339	$85
State/County Special Assistance	$426	0	$213	$213	$277	0	$138	$138
Food Stamps	0	0	0	0	$45	$45	0	0
HCCBG	0	0	0	0	$110	$41	$58	$11
SSBG	$639*	$427	$52	$160	$255	$170	$21	$64
Monthly Totals:	$2,564	$1,377	$718	$468	$1,852	$997	$556	$298
Annualized Totals:	**$30,768**	$16,524	$8,616	$5,616	**$22,224**	$11,964	$6,672	$3,576

*Represents 8% of SA/ACH recipients

	Comparison of Monthly Savings Per Recipient (rounded to nearest dollar)					
	SA/Adult Care Home Cost	**SA/In-Home Cost**	**Savings from SA/In-Home**	**Federal share of savings**	**State share of savings**	**County share of savings**
Medicaid	$1,499	$1,165	$334	$210	$114	$10
State/County Special Assistance	$426	$277	$149	0	$75	$74
Food Stamps	0	$45	($45)	($45)	0	0
HCCBG	0	$110	($110)	($41)	($58)	($11)
SSBG	$639*	$255	$384	$257	$31	$96
Monthly Totals:	$2,564	$1,852	**$712**	$381	$162	$169
Annualized Totals:	$30,768	$22,224	**$8,544**	$4,572	$1,944	$2,028

*Represents 8% of SA/ACH recipients

The average combined monthly cost of $2,564 to support an SA/Adult Care Home recipient is $712 greater, or 38.5% higher, than the average combined monthly cost to support an SA/In-Home recipient, which is $1,852. The annualized difference in costs between the SA/Adult Care Home and SA/In-Home Programs to support one client is $8,544 of which $1,908 is state funds. This indicates that, on a statewide basis, savings of over $12.8 million ($2.9 million in State funds) could be realized on an annual basis by providing SA/In-Home services to 1,500 individuals who otherwise would have entered an adult care home.

VII. Case Management

The ability of older and disabled adults to remain in or move to an appropriate private living arrangement in the community and thus delay or avoid going to an adult care home depends on several factors. Primary factors include: (1) the functional status of the client and need for care and services; (2) availability of family, friends, and neighbors to provide care and services; (3) availability and access to care and services from agencies and other formal service providers; (4) ability to pay for housing; and (5) availability of affordable and safe housing.

In the SA/In-Home Program, case managers at the county departments of social services conduct comprehensive assessments to identify the nature and extent of the impact of these factors on the lives of individuals requesting Special Assistance payments and how the factors affect their ability to live at home. A comprehensive assessment instrument known as the Resident Assessment Instrument© for Home Care (RAI©-HC) is used by the case managers working with these clients.

Using the assessment information, the case managers work directly with the clients and their families and other caregivers to develop a care plan that enables the client to live at home rather than move to an adult care home. The case managers also establish the amount of the SA/In-Home payment, work with the client to determine how the payments are used, and monitor to assure that the payments are used for the intended purpose.

The case manager's role is an essential one in helping the clients remain at home. In addition to the care planning, arranging for services, and monitoring, the case managers also help access community resources unknown to the client. Accessing other community resources has made a critical difference in the client's ability to live at home. The case managers mobilize churches, civic clubs, scout troops, and individual volunteers to provide free labor and materials for minor renovations and repairs to client homes and to install grab bars and other safety devices. They persuade landlords to make needed repairs to apartments and houses rented by the clients, find volunteers to provide transportation for medical care such as kidney dialysis treatment for caregivers so that they can continue to be available to help the client with essential activities of daily living and other tasks that allow the client to continue living at home.

Case management services ensure that the SA funds are used appropriately to reach the target population and to ensure positive outcomes for the recipients receiving services in the home. An average of 1½ hours of case management is provided to each of the SA/In-Home recipients per month. Existing case managers in the county departments of social services provide the case management. Case management is funded through a Medicaid case management program known as At-Risk Case Management. This case management service is funded with 63.49% federal Medicaid dollars and 36.51% county dollars (based on SFY2005-2006 FFP rates). No state funds are used to provide At-Risk Case Management Services. At times, this impacts county DSSs' ability to fill the SA/In-Home slots timely due to limited staffing resources.

The accounts in Appendix C are actual case examples from counties participating in the SA/In-Home Program. They illustrate the types of individuals who received SA/In-Home payments and show how the case managers work with the clients and their families.

VIII. Quality of Life Comparison

The special provision in S.L. 2005-276 directing the Department of Health and Human Services (DHHS) to make a final report to the NC General Assembly included a provision [Section 10.39.(c)] which required the Department to use a standardized quality of life instrument to compare adults receiving Special Assistance in their homes with those in facility settings. A small-scale study was conducted using available resources during Fall 2004. The findings continue to be relevant at this time.

A. The Instrument

Based upon the requirements in Section 10.39.(c), the Department was to "incorporate data collection tools designed to compare quality of life among institutionalized and non institutionalized populations (i.e., an individual's perception of his or her own health and well-being, years of health life, and activity limitations)." In addition to incorporating data collection tools designed to compare quality of life among these populations, the Department was also required to utilize national standards to the extent they were available.

To address the requirements in Section 10.39.(c), an electronic literature review of quality of life instruments was conducted. Based on this review, the Quality of Life Profile: Seniors (Brief Version) as developed by the Centre of Health Promotion at the University of Toronto was chosen as the instrument to use for this purpose. The benefits of this instrument were that it (1) had good face validity, (2) was produced through cooperative efforts of older adults, aging service professionals, and academics in the quality of life field; (3) had been tested successfully for inter-item reliability; (4) had been used successfully with service recipients in both Canada and the United States; and (5) was much more consistent with the social rather than medical view of aging services than other standard quality of life instruments that have been used with similar populations. (See Raphael, Smith, et al., 1995, for further detail on points 2 through 4.)

The Quality of Life Profile: Seniors (Brief Version) produces an overall quality-of-life scale and two additional measures—*control* over ones life and *opportunitie*s for growth and change. The Quality of Life Scale itself is made up of 3 subscales.
These are:

- The *Being* Scale, which deals with physical health, psychological well-being (thoughts and feelings), and spiritual well-being (beliefs and values)
- The *Belonging* Scale, which deals with the physical environment ("where I live and spend my time"), social environment ("the people around me"), and access to community resources
- The *Becoming* Scale, which deals with daily activities, leisure/enjoyment, and growth ("the things I do to improve and change")

For each item in the Quality of Life Scale, respondents are asked both how important to them this is and how satisfied they are with it. The developers of the scale provide a scoring algorithm based on the answers to both questions, weighting the satisfaction response according to the degree of importance the client places on that specific item. For example, if the item "Making my own decisions" was rated very high in importance (5 on a scale of 1 to 5) by people who are very satisfied with their ability to make those decisions (5 on a scale of 1 to 5) they would receive the maximum score (+3.33). Items rated very high in importance (a rating of 5) by people who are very dissatisfied (a rating of 1) receive the minimum score (-3.33). However, items rated very *un*important (1) by people who are very satisfied (5) still receive a positive score, but a much lower one (+0.66). Similarly, items rated as unimportant by people who are very dissatisfied (both ratings of 1) receive a small negative score (-0.66). A table providing the algorithm for assigning scores to each combination of importance and satisfaction scores is available upon request.

Unlike the Quality of Life scales, the Control and Opportunity scales are based on 9 single questions each, and scores range from a low of 1 to a high of 5. The final scores are the average of all 9 items, so these, too, are expressed on a scale of 1 to 5.

B. Sample Selection

North Carolina was divided into four quadrants, and regionally based personnel in the Division of Aging and Adult Services conducted the survey interviews. Four counties were selected in four quadrants of the state—three for inclusion and one to serve as an alternate if there was a problem in one of the other three. Counties were chosen based on participation in the SA/In-Home Program, and included both large and small and rural and urban counties from each quadrant.

Once counties were chosen, the Eligibility Information System (EIS) was used to select a random sample of active SA recipients living in adult care homes and a sample of those living in their own homes. The EIS is a DHHS database containing information about public assistance recipients, including Special Assistance. Interviewers were then asked to follow the random order of the sample in approaching clients to interview. They were instructed that in situations where the client was not physically or mentally able to answer questions, they were to move to the next name on the list, rather than interviewing a caregiver or other proxy. Interviewers were asked to reach 12 in-home and 12 adult care home residents from their selected counties, always taking the same number from each setting for a given county. The table labeled "Sample Size by Program for Quadrants and Their Constituent Counties" shows the distribution of actual interview respondents.

Interviewers participated in an orientation session on conducting the client interviews and completing the survey tool prior to beginning the interview process. They conducted their interviews in person in the client's place of residence (their home or the adult care home in which they resided) following the written protocol.

Interviewers relied on the valuable assistance of staff in county departments of social services to assist with setting up the SA/In-Home client interviews. Interviewers found adult care home administrators to be helpful and cooperative in setting up the interviews for SA recipients in their facilities. Both county departments of social services and adult care home administrators were supportive of the survey process.

C. Demographic Characteristics of the Sample

In addition to the questions on the standardized quality-of-life interview tool, interviewers recorded the gender, race, and age of each client with whom they met. The table labeled "Demographic Characteristics of the Sample, by Region", shows how these varied among the quadrants of the state and between the in-home and adult care home clients.

There are considerably more men in the adult care home sample than the in-home sample (31.2 vs.18.8 percent) as shown in the table labeled "Demographic Characteristics of the Sample, by Region", which gives demographic information for each quadrant and the sample over all. Enrollment data show that about 41.2 percent of SA clients in adult care homes are men, compared to only about 26.0 percent of SA in-home clients. This means that the sample correctly reflects the differences in proportions of men in the two programs, but it also indicates that men in both settings were less likely to be interviewed.

Sample Size by Program for Quadrants and Their Constituent Counties

Quadrant County	**In-home**	**Adult Care Home**	**Total**
Northeast	**12**	**12**	**24**
Hertford	3	3	6
Northampton	6	6	12
Pitt	3	3	6
Wilson (alternate)	0	0	0
Northwest	**12**	**12**	**24**
Caldwell	4	4	8
Catawba	5	5	10
Watauga	1	1	2
Surry (alternate)	2	2	4
Southeast	**12**	**12**	**24**
Cumberland	6	6	12
Johnston	3	3	6
Robeson	3	3	6
Bladen (alternate)	0	0	0
Southwest	**12**	**12**	**24**
Buncombe	6	6	12
Henderson	3	3	6
Transylvania	3	3	6
Haywood (alternate)	0	0	0
Total	**48**	**48**	**96**

The distribution of African Americans in the sample reflects the historical ethnic distribution within North Carolina, with many more African Americans living in the two eastern quadrants than in the two western ones. It also mirrors the persistent national finding that African American elders are less likely to be placed in residential settings than White elders. (All respondents were African American or White except for two American Indians in adult care homes in the southeast.) Thus in the sample, 45.8 percent of in-home clients were African American, which is very close to the overall state enrollment in the program (41.6 percent African American). However, in the adult care home sample, only 22.9 percent of clients were African American, which is similar to the overall enrollment figure for SA clients in adult care homes at 27.3 percent.

Demographic Characteristics of the Sample, by Region

	% Male			% African American			Average Age		
Region	**In-home**	**ACH**	**Both settings**	**In-home**	**ACH**	**Both settings**	**In-home**	**ACH**	**Both settings**
Northeast	25.0	25.0	25.0	100.0	33.3	66.7	61.2	68.3	64.8
Northwest	16.7	16.7	16.7	16.7	0.0	8.3	69.1	68.3	68.7
Southeast	25.0	50.0	37.5	66.7	33.3	50.0	70.5	67.4	69.0
Southwest	8.3	33.3	20.8	0.0	25.0	12.5	72.2	68.5	70.3
Total	*18.8*	*31.2*	**25.0**	*45.8*	*22.9*	**34.4**	*68.2*	*68.1*	**68.2**

The mean age for both in-home and adult care home residents was just over 68, but the range was from 25 to 95, with just over 28 percent of respondents younger than 60. While the three respondents who were in their twenties were all in-home clients, there were actually slightly more people under age 60 in the adult care homes (31.2 percent) than in the in-home program (25.0 percent), but this difference is not statistically significant. In the underlying SA population, 27.4 percent of the clients are younger than 60. Thus, this sample appears to be a reasonable reflection of the population from which it was drawn.

To the best that can be determined from available demographic data, the sample is quite representative of the demographic characteristics of the SA population except for the under representation of men in both the SA/In-Home and SA/Adult Care Home Programs. Because there are real racial and gender differences in the participants in these two programs, it was important to make sure any differences in their quality of life scores were not influenced by these differences.

D. Effects of Sample Size

Because available resources limited the sample size, it is only possible to show statistical significance for relatively large differences between the in-home and adult care home samples. Statistical significance means that the differences in the sample are so large that there is only a small chance (1 in 10, 1 in 20, or 1 in 100, depending on the level chosen) that the difference exists only in the sample and not in the larger population that the sample represents (i.e., recipients of SA in NC).

With a small sample, there is always an increased chance of Type II errors, which arise when the difference in the sample reflects a real difference in the population that does not meet the criteria for significance. While some differences between the two groups are clearly minimal and seem to show conclusively that the setting does not affect those particular aspects of quality of life, there are some that are not quite statistically significant but which might indicate differences that would be significant in a larger sample. For purposes of this report, these findings will be called *suggestive.*

E. Comparison of Quality of Life Scores between SA/In-Home and SA/Adult Care Home Clients

Quality of Life—Belonging, Becoming, Being

The Belonging subscale is an area in which clients receiving SA at home are *clearly* more satisfied with the quality of their lives than those in adult care homes. This subscale contains nine items, with three items each in components that measure satisfaction with physical, social, and community environment. The average score for in-home clients was 1.69, compared to 0.85 for those in adult care homes, and the differences are statistically significant for the subscale overall and for each of its three components.

The Becoming subscale reflects satisfaction with activities, leisure, and growth. The two groups had identical scores on the overall subscale (0.66) and similar low, but slightly positive, scores on each of its components. Although the scores are affected by the age and race of the respondents, they are not affected by where the respondents were living.

The Being subscale has components measuring thoughts and feelings, spiritual life, and physical well-being, and the results for each differs depending on where the respondents were living. On the component dealing with thoughts and feelings, in-home clients scored significantly higher (1.22 compared to 0.78). In-home clients in the sample also scored higher on the component dealing with spiritual life (1.23 compared to 0.83), but this difference falls short of statistical significance, although it is suggestive. Similarly, the difference in satisfaction with physical well-being was suggestive but not significant, but for this component, residents of adult care homes had higher scores, though neither group reports a very high quality of life in that dimension (0.71 compared to 0.26). The finding that in-home clients appear to rate themselves lower on physical well-being–specifically about getting around home, energy, and physical health—may reflect how they compare themselves to the people around them. People in adult care homes may look at other people in the facility and feel that they are fairly healthy and energetic by comparison, while those at home, looking at their friends and neighbors, may feel that they are not in very good physical shape.

For the overall Quality of Life Scale (the three subscales combined), both groups gave a low, but positive, rating. On a scale from -3.33 to +3.33, the average score for in-home clients was +1.06, and the average score for clients in adult care homes was +0.81. This difference also is suggestive rather than statistically significant. There were no areas in which the adult care home clients scored significantly higher than the in-home clients, although there was one component in which they had suggestively higher scores as described above.

The Control and Opportunity Scales

The Control and Opportunity Scales were scored differently than the general Quality of Life scale. They did not combine importance with satisfaction nor did they include negative and positive scores. They simply averaged 9 items, each of which asked "How much *control* do you have over. . .?" or "Are there *opportunities* for you to. . . ?" Each item was scored on a scale of 1 to 5 in which 1 means "None" and 5 means "A lot." When responses to such 5-point scales are averaged, fairly small differences are quite meaningful.

In the case of the Control Scale, scores for both groups fell between 3 and 4, but in-home clients had an average of 3.76, which is close to the 4 rating ("Quite a bit"), while the adult care home residents had an average score of 3.41, closer to the "Some" rating. This overall difference is statistically significant. In particular, in-home residents scored significantly higher on the items "How much control do you have over where you are living or will be living?" and "How much control do you have over who you spend your time with?" as well as suggestively higher scores on three additional items. The other four items appeared not to differ much between the two groups, although the in-home respondents did score slightly higher in three out of four. It is clear that SA in-home clients feel a greater sense of control over their lives than those in adult care homes.

Scores for the Opportunity Scale overall were not significantly different for the two groups. However, there are both suggestive and significant differences for the individual items that make up this scale. SA In-Home clients scored these statements significantly higher than did residents of adult care homes: "Opportunities to improve or maintain how you think and feel about things?" and "Opportunities to live in a comfortable and pleasing place?" However, residents of adult care homes' scored three items sufficiently higher to suggest that they might be significant in a larger sample. These were "Spend time with different people?" "Do different daily activities than you do now?" and "Learn and do new things?" This finding, if confirmed, would be reasonable in light of the activities provided in adult care homes and the larger number of people in facilities than in the environment of an older or disabled adult living at home.

F. Summary of Findings

As shown in the table below, people who receive Special Assistance at home rate their quality of life significantly higher in the areas of feelings/emotions, physical environment, social environment, and community access. They also believe that they have more control over their lives. In general, there is no difference between clients in the two settings in their feelings about their opportunities to grow and change as measured on two different scales (Becoming and Opportunities). There are no areas in which clients receiving Special Assistance in adult care homes score significantly higher than those living at home in the community, although there are several areas in which the two groups appear to differ (some rated higher by in-home clients and some by clients in adult care homes). Because the sample size in this study is too small to allow us to understand whether these differences are significant, it will be interesting to learn more about ratings of quality of life as evaluation of the two Special Assistance Programs continues.

Summary of Findings for Items in the Quality of Life Profile by Place of Residence

Values in **bold face** are significant at the 0.1 level or better. Values in *italic* might be significant in a larger sample.

	Place of Residence	
Item	**In-home**	**ACH**
Being Score	0.905	0.830
Physical Being (body and health)	*0.262*	*0.709*
Psychological Being (thoughts and feelings)	**1.222**	**0.778**
Spiritual Being (beliefs and values)	*1.230*	*0.831*
Belonging Score	**1.687**	**0.846**
Physical Belonging (physical environment)	**1.821**	**0.964**
Social Belonging (people in the environment)	**1.527**	**0.852**
Community Belonging (access to community resources)	**1.779**	**0.686**
Becoming Score	0.665	0.665
Practical Becoming (daily activities)	0.491	0.544
Leisure Becoming (activities for enjoyment)	0.683	0.642
Growth Becoming (coping skills and making changes)	0.820	0.776
Control	**3.762**	**3.417**
Opportunity	3.333	3.292

1. Technical Notes

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Effects of Demographic Variables on Scores
As mentioned earlier, interviewers collected data on the age and race of respondents, and respondents have been categorized by setting (in-home or ACH) and region of the state (East or West). The difficulties in identifying findings as significant increase as one looks at smaller subgroups of the sample because there are fewer in any group (e.g., African American men living in the west who are 65). Nonetheless, there are a few identifiable relationships among the quality-of-life scores and demographic variables.

Age is significantly and negatively related to opportunity score. That is, the older the client, the lower the rating he or she is likely to have given the opportunities for growth and change. This relationship holds true in both in-home and adult care settings, regardless of race. Men in the sample, on average, report higher opportunity scores than women. However, they also tend to be younger than women. When one controls for age, the relationship between gender and opportunity disappears.

An example of a suggestive finding is that, on average, men in the sample scored higher on the Being subscale of the Quality-of-Life Scale. This difference actually increases slightly when age, race, region (East or West), and setting (in-home versus adult care home) are controlled. However, it is *not* statistically significant with or without those

variables controlled. As described above, this means one cannot be sure that the finding (that men are more satisfied with their physical, emotional, and spiritual well-being than women) applies to the whole group of people receiving Special Assistance. This can only be known with a larger sample size.

If only pairs of client characteristics are examined, there are suggestive relationships between the Becoming subscale (activities, leisure, growth) and both race and age, and when region, gender, and setting are controlled, both of these variables *are* significant. Compared with people of their same gender, setting, and region, younger clients are more satisfied with the quality of their daily activities, leisure, and personal growth than older clients of their same race, and White clients were more satisfied with those factors than African American clients within their same age group.

Because of these proven and suggestive relationships between the demographic and regional characteristics of the clients, all significant differences between people in adult care homes and those receiving SA at home were re-tested with demographic and regional variables controlled. In no case did this change the significance of the basic relationship.

Multivariate Modeling

Linear regression was used to test for the persistence of significant zero-order relationships with scale and subscale scores while controlling for age, gender (male), race (African American), and region (East). Only the model for the Belonging Subscale was both statistically significant and had meaningful explanatory power (*R*-squared = 0.217). Scores and probability scores for all of the bivariate relationships between setting and component scores and regression results are available upon request.

IX. Summary

The General Assembly authorized the Department of Health and Human Services to provide State/County Special Assistance to a limited number of older and disabled adults. The Quality of Life comparison indicates that SA/In-Home Program participants perceive more control of their lives and feel a greater sense of belonging than those receiving SA payments in an adult care home. The SA/In-Home Program has shown that providing Special Assistance payments to individuals to enable them to continue living at home is cost effective as an alternative to placement in an adult care home.

The cost analysis period for this report is July 2005 through June 2006. The analysis shows a significant difference in costs; SA/Adult Care Home costs are 38.5% higher than the SA/In-Home costs. The findings described in this report continue to demonstrate the trend of the cost savings realized by the SA/In-Home Program.

A. Cost Savings

The cost or cost savings that could occur as a result of making the SA/In-Home Program available in the remaining 13 counties of the state is somewhat difficult to estimate. However, as the data in this report indicates, a cost savings of $12.8 million ($2.9 million State) could be realized on an annual basis with 87 counties participating in the Program and utilizing the 1,500 slots currently available. It is possible that there would be no increase in the SA budget as a result of expanding the program statewide. One requirement for receiving SA payments at home is that a physician authorize that adult care home level of care is needed. It is likely that some eligible individuals who need adult care home level of care would opt to stay at home rather than choosing placement in an adult care home. If this occurred, there would be no increase in the SA budget. In fact, if some individuals chose the SA/In-Home option, this would result in a significant cost savings for the Special Assistance budget. The SA/In-Home payments average $1,788 per recipient per year less than the SA/Adult Care Home payments ($277 per month for In-Home payments versus $426 per month for adult care home payments).

In addition to the potential for cost savings in the Special Assistance budget, there would likely be no significant increases in the Medicaid budget for SA/In-Home recipients. These individuals are eligible for Medicaid and Medicaid-covered services whether or not they receive SA/In-Home payments. Also, the food stamp benefits paid to these individuals were relatively small ($45 per month), are 100% federally funded, and do not impact the state budget.

B. Start-up and Expansion Experiences

The experience with the SA/In-Home Program over the past five years shows that when the program begins operation in a new county, a great deal of local education and community awareness must take place before referrals are received. The identification of participants requires assistance of many local agencies, such as home care/home health providers, adult day services, and aging agencies. These local networks are targeted by

county DSSs for informational presentations about the SA/In-Home Program. As awareness of the program builds in the community, referrals are generated.

The provision of case management has proven expensive to the county DSSs since it is provided under a Medicaid program that requires a 36.51% county match because no state funds support this case management program. County DSS directors must gain support of county commissioners and managers to provide the required level of county match funding before undertaking the SA/In-Home Program.

The SA/In-Home Program requires a comprehensive assessment for all applicants to determine their service needs. The automated RAI©-HC assessment tool was designed to be used as a stand alone program loaded on laptops. Use of a laptop allows the case manager to complete the assessment in the individual's home and to collect data for state reporting purposes. The computer hardware provided to the county DSSs engaged in the SA/In-Home Program is becoming increasingly obsolete. Many failures have been experienced leading to the need to secure substitute laptops locally. Frequently local budgets cannot absorb the cost of replacement laptops.

The county DSSs have different technical support systems, and their technical expertise and hardware varies greatly. A number of DSSs experienced difficulty in using the automated RAI©-HC tool because of changes in operating systems on their laptops since 2000. This led to subsequent difficulties since the SA/In-Home Program's assessment software was built on Access 97, which is an outdated version. Staff from the Division of Aging and Adult Services, with support from the Division of Information Resource Management (DIRM), have worked individually with each DSS experiencing problems to get their systems running properly. This created delays in start-up for those DSSs. DIRM released a version of the SA/In-Home Program's assessment software during the Fall 2005 that operates with Access 2002 and 2003, thereby resolving this problem.

Several consecutive years of budget shortfalls have created uncertainty about funding in DSSs as they struggle to balance numerous priorities against limited staff resources. Much of the Adult Services case managers' time is involved with mandated services. In some cases this has restricted the DSSs' efforts at educating and involving other local agencies and resulted in a more gradual gearing up of the Program than the DSSs anticipated.

The experience over the past six years of development and implementation of the SA/In-Home Program leads the Department to a set of recommendations that would be logical next steps as described in the Recommendations section which follows.

X. Recommendations

Making the SA/In-Home Program available in all counties of the state will provide older and disabled adults the option of living in their own homes in the community instead of moving to an adult care home. The growth in the number of filled slots over the past year shows that the Program is an important option in allowing individuals a choice in settings of care and that remaining at home is a desired option. Slot utilization has tripled, increasing by over 209% since January 2004. Several issues were identified during the start-up and expansion of the SA/In-Home Program that must be taken into account to make the program available in all counties and these are addressed in the following recommendations.

A. Provide Permanence through a Statutory Basis for the Program

Uncertainty about the future of the program led to a decrease in the number of filled slots from 326 on July 1, 2002, to 267 on June 1, 2003. This was a time-limited demonstration project at that time and required legislative approval to continue beyond June 30, 2003. For some families, there was significant concern that individuals choosing to receive services at home might lose those benefits if this time limited demonstration project was discontinued. With the uncertainty of the continuation of the Program, some families had to go ahead and make decisions about placement to assure that adequate care was available for their family members. Some recipients left the Program due to normal attrition during this time, and the number of filled slots dropped.

Participation has steadily increased since the expansions of the program by the General Assembly in 2003, 2005 and 2006. The Program has expanded to serve 965 recipients in 87 counties as of December 1, 2006 and will continue to expand as the 15 counties enrolled in the Program during September 2006 begin providing the service. The 500 additional slots awarded in September 2006 are beginning to be utilized at this time. Elevating the status of the SA/In-Home Program from Special Provision status to General Statute would prevent a recurring sense of uncertainty of the Program's future and stem family reluctance to participate. This recommendation can be accomplished with no additional fiscal impact.

B. Provide a State Appropriation for Case Management Costs

Case management is essential to the successful implementation of the SA/In-Home Program. Case mangers are conducting comprehensive assessments to: determine the need for services; make referrals for important medical, health and other social services; and determine, in collaboration with the client and family, how best to use the SA/In-Home payment. Case managers follow up to assure that the payments and other services are appropriately utilized as well as to assure that services are provided as expected.

This case management is funded through a Medicaid case management service known as At-Risk Case Management. Approximately 1½ hours of case management per client per month is provided to the SA/In-Home recipients. Currently, it is funded with 64.52% (FFP rate effective October 2006) federal Medicaid dollars and 35.48% county dollars.

Currently counties provide the entire 35.48% match for the non-federal share. No state funds are used to provide this case management service. This is one of only two case management services funded by Medicaid with no state participation in the cost of the service.

The NC Association of County Directors of Social Services (NCACDSS) has supported the SA/In-Home Program from its inception as a demonstration project as well as the expansion from 800 to 1,000 slots in August 2005, and the expansion to 1,500 slots in July 2006. The NCACDSS believes the SA/In-Home Program is an important component of the long-term-care service delivery system as it provides choice and creates an option for older and disabled adults to remain safely at home. In the 87 county DSSs participating in the Program, case management services have been provided with existing staff resources. With limited staff resources and the other services that county DSSs are mandated to provide for older and disabled adults, it is not feasible to fully sustain the SA/In-Home Program in the 87 counties nor expand the Program into the remaining 13 counties without additional staffing resources. The inability to obtain the county match funding for At-Risk Case Management Services is the primary reason the remaining 13 county DSSs are unable to participate in the SA In-Home Program at this time.

Adult services staff in county DSSs already have large caseloads. In many instances, the staff who deal with the priorities of receiving and evaluating reports of adult abuse, neglect, and exploitation and respond to the needs of adults for whom the DSS is legally appointed as guardian are also the staff responsible for the SA/In-Home Program. County DSSs have identified limited staff resources as a barrier to conducting client assessments necessary for determining eligibility, which then delays filling slots on a timely basis.

At-Risk Case Management services are provided by county DSS to people of all ages. SFY2005-2006 expenditures were $8,558,400. State participation in the cost of At-Risk Case Management services to provide adequate staffing resources is needed to support the maintenance and expansion of the Program statewide. A State appropriation at the rate of 17.74% would cost $1,518,260 annually.

C. Procurement of Hardware/Software and Additional State Level Resources to Maintain and Expand the Program

The laptops supporting the SA/In-Home Program in the 87 counties, which were purchased by the State in 1999, are at varying stages of obsolescence. Many of the laptops are no longer functional and either cannot be repaired or the cost of repair exceeds the cost of new equipment. Frequent repairs to the laptops and/or several staff having to share a limited number of laptops create inefficiencies in the Program and delay assessments to determine eligibility and fill empty slots.

To successfully maintain the SA/In-Home Program in the 87 counties and to support the expansion of the Program into the remaining 13 counties, two new laptops per county are needed, equipped with the latest version of Access software.

A Social Services Coordinator position is needed within the central office of the Division of Aging and Adult Services to adequately manage the growth of the SA/In-Home Program. This position will be responsible for tracking and managing slot usage, developing program policies and procedures, coordinating with other SA and Medicaid staff, developing and providing statewide training, and providing technical assistance to county DSS case managers and SA eligibility staff. The position will also assist county DSSs by creating and providing resource materials and training events directed to elevating community awareness and effectively marketing the Program. Currently only a portion of the SA Program staff time is available to support the SA/In-Home Program within the Division of Aging and Adult Services.

Laptop procurement costs and Coordinator costs are displayed below:

	SFY2008	SFY2009	SFY2010	SFY2011	SFY2012
Laptops (200)	$415,000	0	0	0	0
Social Services Coordinator	$54,821	$69,976	$69,976	$69,976	$69,976
Total:	$469,821	$69,976	$69,976	$69,976	$69,976

[1] SFY2008 costs for the coordinator position assume an October 1, 2007 starting date and include one-time expenses required to set up an office. Fringe benefit, travel, and other overhead expenses associated with the position are included in each fiscal year.

APPENDIX A

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

Senate Bill 622

SECTION 10.39.(b) The Department shall report on or before January 1, 2006, and on or before January 1, 2007, to the cochairs of the House of Representatives Appropriations Committee, the House of Representatives Appropriations Subcommittee on Health and Human Services, the cochairs of the Senate Appropriations Committee, and the cochairs of the Senate Appropriations Committee on Health and Human Services. This report shall include the following information:
(1) A description of cost savings that result from allowing individuals eligible for State-County Special Assistance the option of remaining in the home.
(2) A complete fiscal analysis of the in-home option to include all federal, State, and local funds expended.
(3) How much case management is needed and which types of individuals are most in need of case management.
(4) The geographic location of individuals receiving payments under this section.
(5) A description of the services purchased with these payments.
(6) A description of the income levels of individuals who receive payments under this section and the impact on the Medicaid program.
(7) Findings and recommendations as to the feasibility of continuing or expanding the in-home program.
(8) The level and quantity of services (including personal care services) provided to the demonstration project participants compared to the level and quantity of services for residents in adult care homes.

SECTION 10.39.(c) The Department shall incorporate data collection tools designed to compare quality of life among institutionalized versus noninstitutionalized populations (i.e., an individual's perception of his or her own health and well-being, years of healthy life, and activity limitations). To the extent national standards are available, the Department shall utilize those standards.

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APPENDIX A

SESSION LAW 2006-156
HOUSE BILL 2576

AN ACT TO INCREASE THE NUMBER OF ASSIGNMENTS TO THE SPECIAL ASSISTANCE IN-HOME PROGRAM OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. Funds appropriated to the Department of Health and Human Services for the 2006-2007 fiscal year may be used to increase the maximum number of assignments to the special assistance in-home program to 1,500 persons.

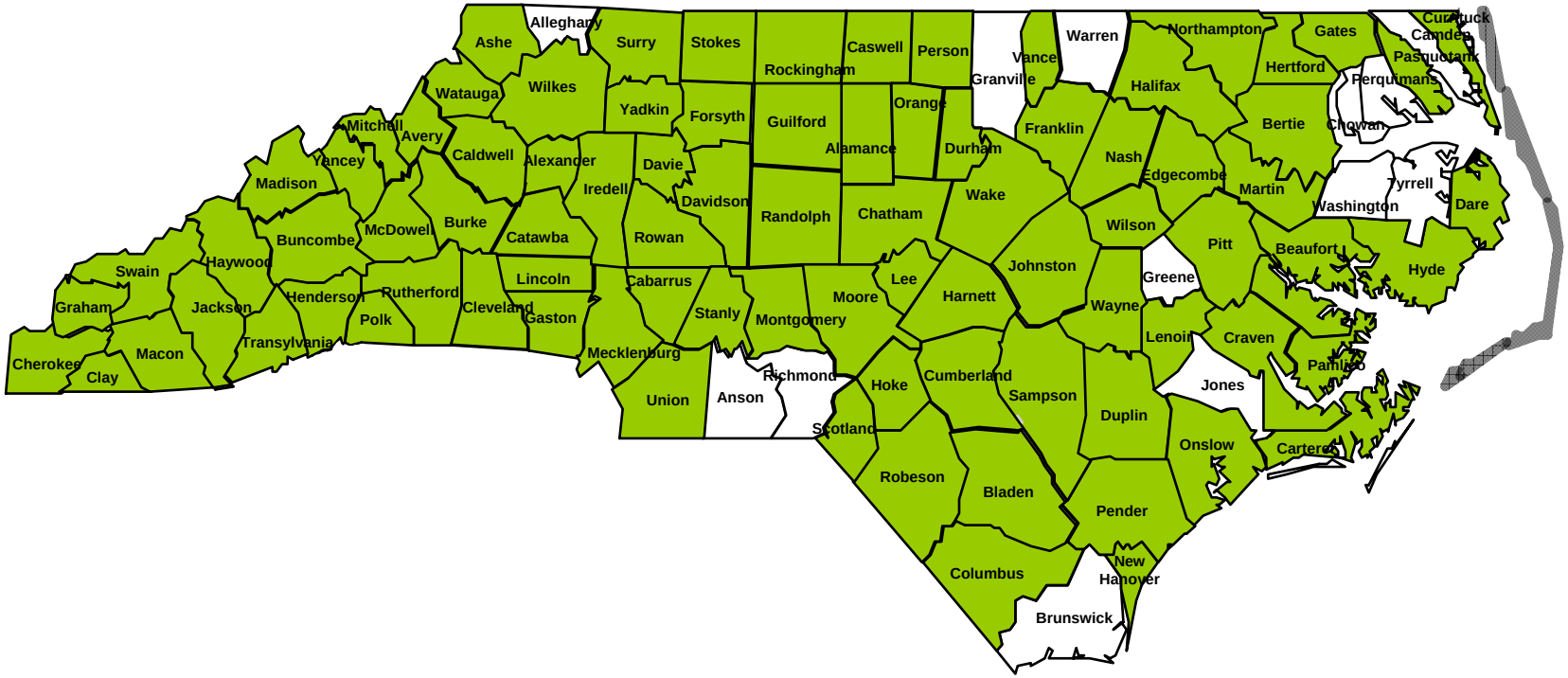
SECTION 2. This act becomes effective July 1, 2006.

In the General Assembly read three times and ratified this the 13th day of July, 2006.

Appendix B

Special Assistance In-Home Participating Counties

November 2006



Geographic Location of the 965 SA/In-Home Clients (December 1, 2006)

	Number of SA/In-Home clients		Number of SA/In-Home clients		Number of SA/In-Home clients
Alamance	5	Forsyth	28	Orange	6
Ashe	6	Franklin	12	Pamlico	2
Beaufort	3	Gaston	26	Pasquotank	24
Bertie	1	Graham	33	Pender	3
Bladen	7	Guilford	51	Pitt	12
Buncombe	25	Halifax	15	Randolph	10
Burke	5	Harnett	15	Robeson	34
Cabarrus	42	Haywood	22	Rowan	15
Caldwell	9	Henderson	30	Rutherford	5
Caswell	2	Hertford	15	Sampson	4
Catawba	10	Hoke	4	Scotland	3
Chatham	10	Iredell	10	Stanly	1
Cherokee	3	Johnston	23	Stokes	6
Clay	1	Lee	16	Surry	9
Cleveland	46	Lenoir	13	Swain	6
Columbus	8	Lincoln	9	Transylvania	14
Craven	7	Martin	8	Union	7
Cumberland	48	McDowell	5	Vance	10
Currituck	4	Mecklenburg	19	Wake	25
Dare	13	Moore	8	Watauga	4
Davidson	8	Nash	14	Wayne	20
Davie	5	New Hanover	13	Wilson	17
Durham	26	Northampton	30		
Edgecombe	3	Onslow	12		

APPENDIX C

Case Examples

Individuals who wish to participate in the SA/In-Home Program must have income below the federal poverty level (currently $817 per month) and be eligible for Medicaid; have an FL-2 [1] indicating a need for adult care home level of care; and have an assessment and service plan that indicates the individual can live safely at home with services. The following case examples were submitted by county DSS case managers as illustrations of how the SA/In-Home Program has been helpful to their clients.

[1] The FL-2 is a form signed by a client's physician which indicates the recommended level of care.

These accounts are actual case examples gathered from some of the participating counties over the years the program has operated. They illustrate the types of individuals who received SA/In-Home payments and show how the case managers work with the clients and their families.

County: Forsyth

Client (60) is a cancer victim (throat cancer). He lives in a single wide trailer with 6-7 other people. Client's funds have been going toward medical expenses and living expenses. Client requires liquid supplements and soft foods for his diet. He has an open hole in his throat and is a "neck breather". He is not able to talk. SA In-Home funds are used to purchase dietary supplements on a regular basis for client. Client does not want to live anywhere else. He fears that being in a nursing home or adult care home would kill him.

County: Bertie

Client lives in own home in a rural area with her nineteen-year-old daughter and suffers with chronic heart conditions-open heart surgery and several heart bypasses. SA In-Home program was a resource in purchasing a lift chair to relieve weight bearing and lifting by family (enabling client and family to perform personal care tasks medically correct) to pay an increasingly high electric bill in order to ensure continued power for client's oxygen machine, to assist in the purchase of a clothes dryer and minor repair of client's roof caused by an abrupt storm. The Special Assistance In-Home program is an economic resource for medical equipment to continue to administer treatment essential for the client. Client's physician recommended adult care home level of care.

County: Bertie

Client lives alone in rural area and wants to remain living in her home, but does not feel comfortable being at home at night. The SA In-Home program is paying for in-home

care at night. The Special Assistance In-Home program is providing services to allow client to remain living in her home with comfort and peace of mind as long as possible. Client's physician recommended adult care home level of care.

County: Moore

Because of the SA-In-Home program, a 92 year old female client has been able to pay off an outstanding kerosene bill that, at one time, was over $500.00. She was also able to use the SA In-Home money to make a number of necessary home repairs. According to the home repair person, "Without these repairs, the client was in danger of falling through the floor of her home." Some of the repairs and purchases that were made using SA In-Home money include a new electric stove, new bathroom vanity, new sub-flooring, and vinyl flooring in the bathroom. The client can now walk in her bathroom without fear of the floor giving way. More necessary home repairs are to be made. Without the SA In-Home program the client, whose monthly income totals $584.00, could not have afforded any of the above and would continue to live in an unsafe home.

County: Moore

Another 85-year-old female client with a cancer diagnosis was living with her daughter and her family who were providing all care to the client. The family was struggling financially due to the level of care needed on a daily basis for client; at times the client required round-the-clock care, which her family tirelessly provided. The cost of medical supplies, prescription co-pays, and transportation costs as well as food and shelter costs were difficult on a family already struggling due to a fixed income. Because of SA In-Home money, the client's quality of living was enhanced merely by the ability to pay for bare necessities. The client was able to remain at home with her loved ones until her final hospitalization prior to her death.

County: Henderson

Ms. B is a 56-year-old who has had a stroke and has vascular dementia with delusions. An Adult Protective Services Social Worker referred Ms. B to the SA In-Home program. Ms. B lives alone and has difficulty keeping up with her bills and has a recurring problem of having her utilities disconnected due to lack of payment. Ms. B attends adult day care Monday-Friday and has a home health RN that sees her on Saturday and Sunday for administration of medications. Ms. B also gets Personal Care Services 5 times a week. Ms. B was admitted to an adult care home for a short time after her stroke, but then returned home and expressed a strong desire to remain there. After Ms. B was assessed for the SA In-Home program the case manager felt it was necessary for her to have a representative payee in order to be able to manage her funds appropriately. Ms. B agreed to have a payee and this was included in her service plan. Ms. B needed additional money just to meet her ongoing monthly expenses and be able to purchase food. All of the agencies involved with Ms. B had a meeting and Ms. B was also included. The

agencies discussed who would be responsible for what aspect of Ms. B's service plan and how we could assist her in staying home safely and successfully. With the cooperation of several agencies, Ms. B has a plan that will allow her to remain in her own home safely.

County: Scotland

D.K. is a 41-year-old female who currently lives with her parents. She suffered a massive stroke in August 2003. She was placed in a nursing home after several weeks in the hospital. With physical therapy and family support she improved enough for her to be discharged to her parents' home as an alternative to a step-down placement in an adult care home. She has cognitive impairment and is never left without supervision. The SA In-Home funds are used to cover Adult Day Care Services for three days a week. This service provided respite for her caregivers and interaction with others as well as stimulation. Beginning in October 2004, she received funding for Adult Day Care from another source and the SA In-Home funds are now used to offset the cost of dietary supplements that she needs four times a day to help maintain weight and nutrition. The funds are also used to assist with transportation costs of all her routine medical appointments. D.K. has received physical therapy and speech therapy. D.K. is able to remain in her parent's home with the help of the SA In-Home program.

County: Sampson

Our agency received an Adult Protective Service call regarding a woman who had been taken out of the local nursing home by her son. Over the past year, the SA In-Home Program has enabled client to remain in her home rather than returning to facility care. The SA In-Home Program has enabled client to purchase a telephone for emergency use. She has also been able to afford a hand rail for her outdoor steps that lead to her home. She has made electrical repairs to her home that resulted in lowering her electric bill. Client is able to purchase medical supplies, such as dietary supplements, that are not covered by Medicaid or Medicare. Client is also able to afford her doctor's co-payments. Since returning to her home, client has gained weight, had her skin cancer removed, and she has improved her relationship with her family. Client stated that she is very thankful for the SA In-Home Program.

County: Buncombe

The first client approved for the SA In-Home program was not receiving any services, and was not aware that any existed. She now receives Medicaid PCS. Through SA In-Home funding, she is kept much safer at home by wearing a Personal Emergency Response System button. She also uses the funds for help in paying utility bills, and for assistance with her over-the-counter medications and prescription co-payments.

County: Guilford

Ms. O is very thankful for the Special Assistance In-Home benefits she receives. Without the benefits, Ms. O would not be able to purchase the proper nutritional food items needed on an ongoing basis to keep her diabetes under control. Ms. O would be confined to her apartment, only going to doctor appointments as she would not be able to afford the cost of adult incontinence undergarments and pads, which she desperately needs because of her bladder problem. Prior to Ms. O receiving SA In-Home benefits, she was able to only partially pay her monthly utility bills. SA In-Home benefits have relieved Ms. O of the stress of worrying each month if her utilities are going to be disconnected due to partial payments.

County: Wayne

Since the SA In-home program began in October 2004 in our county, it has helped so many people that it is difficult to pick just one, but the one that stands out the most is Ms. K. Ms. K is a 61-year-old lady who is blind, has seizures and severe arthritis in her knees. She has been widowed for several years, but as she has gotten older, it has become more difficult for her to manage on her own. She has a personal care aide who goes in for two hours each day, but otherwise, she is alone. She also lives in government subsidized housing in a less than ideal part of town. The SA In-Home program got her established with a personal response service. Ms. K has a difficult time getting up and down from her chair, so if she should fall, she has the response system to call for help. She is also at risk for seizures; but says that she always knows when she is getting ready to have one, and would have time to press her button to call for help. Ms. K is now receiving Meals on Wheels for lunch. She is also able to hire someone to come in and help her couple of hours each day in the afternoon and prepare supper for her. Without the SA In-Home program, Ms. K would not have been able to continue living at home by herself.

County: Cleveland

Mr. R suffers from multiple health problems that are debilitating, including cancer. A friend assists with his care. Mr. R values being as independent as possible and wants to avoid out of home placement. Mr. R utilizes the SA In-Home funds to pay for assistance with his care, for utility bills as well as special food for his recommended dietary needs. Without the SA In-Home assistance, Mr. R's needs could not be met and out of home placement would be necessary.

County: Northampton

Mr. and Mrs. C. have been on the SA In-Home program for the past 3 years. Mr. C. is 80 years old with right side paralysis secondary to a CVA he had 4 years ago. His mobility

is also limited due to degenerative joint disease. When first admitted to the SA In-Home program, Mr. C. was bedridden and rarely used his wheelchair. There was no wheelchair access for entering or leaving the home, and he only left his home when transported by rescue. His clothes were soiled often due to incontinence making him prone to skin breakdown; and, there were piles of soiled laundry throughout the home because the washing machine was broken.

Mrs. C. is 78 years old and is wheelchair bound due to degenerative joint disease and morbid obesity. She also suffers with chronic asthma and diabetic polyneuropathy. At the time of admission to the SA In-Home program, both clients were receiving basic Medicaid PCS Monday through Friday. However, no consistent caregiver was in the home after 1:00 pm on weekdays, and there is no one to care for this couple on weekends. Both clients require extensive assistance daily with care, toileting needs (due to incontinence), transfers and medication monitoring. In addition, they require total care for meal preparation and general home maintenance.

Mr. and Mrs. C.'s home was roach infested, had rotted flooring in the bathroom and hallway. The toilet was broken and cracked, the washing machine was non functional, and there was a sewage line problem.

The SA In-Home payments were used to repair the rotted flooring in the bathroom and hallway; purchase a new washing machine; and purchase and install a new toilet.

The SA In-Home payments are currently used to pay for additional personal care hours so that an aide is in the home more frequently to assist both Mr. and Mrs. C with basic care.

Other services coordinated by case management include:

1. Involving family in clients' care for weekly grocery shopping, errands, transportation to appointments, daily checking in on clients, cleaning out clutter in the home, roach eradication, and sewage line repair
2. Referral to community services for construction of wheelchair ramp to front entrance of home
3. Purchase of motorized wheelchair for Mr. C. and repair of manual wheelchair for Mrs. C.
4. Referral to Health Dept./Home Health for incontinent supplies, Blood pressure monitoring and assessment of general health status and skin condition every 60 days
5. Referral for palliative foot care every 4 months

County: Robeson

Ms. L is a 78 year old female with a primary diagnosis of Alzheimer's End Stage. Ms. L has been receiving additional personal care hours from the Special Assistance In-Home program since August 2003. She is bed confined at this time and is unable to perform any personal care activities and requires 24 hour supervision.

The family has faced many challenges since caring for their mother and most of them still work full-time jobs. The social worker visiting the home has seen many physical/ mental changes with her. This program has helped the family fulfill her desire to remain in her own home instead of being placed.